STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08A011	A. BUILDING _____ B. WING _____	08/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE STAR FOULK MANOR NORTH LLC	1212 FOULK ROAD WILMINGTON, DE 19803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced annual survey was conducted at this facility from August 27, 2018 through August 30, 2018. The facility census the first day of the survey was 34. During this period, an Emergency Preparedness survey was also conducted by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection in accordance with 42 CFR 483.73. For the Emergency Preparedness survey, no deficiencies were cited.	E 000		
F 000	INITIAL COMMENTS An unannounced annual and emergency preparedness survey was conducted at this facility from August 27, 2018 through August 30, 2018. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other documentation as indicated. The facility census the first day of the survey was 34. The survey sample size was 22. Abbreviations / definitions used in this report are as follows: ADON -assistant director of nursing; Advanced Directive - legal document signed by a competent person to provide guidance for medical and health-care decisions in the event the person becomes incompetent to make such decisions; Alzheimer's Disease - degenerative disorder that attacks the brain's nerve cells resulting in loss of memory, thinking and language; Antibiotic - medication used to treat bacterial infections; Calcium Carbonate - an insoluble salt occurring	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/24/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1	F 000		

naturally in bone, used as an antacid, calcium supplement, and phosphate binder, and for treatment of osteoporosis;
CNA - Certified Nurse's Aide;
Dementia - a severe state of cognitive impairment characterized by memory loss, difficulty with abstract thinking, and disorientation OR loss of mental functions such as memory and reasoning that is severe enough to interfere with a person's daily functioning;
DON - director of nursing;
ED - executive director;
Essential tremor- nervous disorder that causes rhythmic shaking;
FlexPen - trademark for a device to administer insulin that is prefilled and color-coded. It allows for accurate measurement by dialing the number of units to be administered;
eMAR- Electronic Medication Administration Record;
Gerichair - wheelchair type- chair that reclines;
Hypothyroidism -under active thyroid gland that includes symptoms such as fatigue, weight gain, muscle weakness, muscle aches, slowed heart rate, memory problems and depression;
Incontinence - lack of voluntary control over urination or defecation;
Insulin - a hormone that lowers the level of glucose (a type of sugar) in the blood by helping glucose enter the body's cells. Doctors use this hormone to treat diabetes when the body can't make enough insulin on its own;
Ischium - bony areas on each buttock;
Levothyroxine Sodium (Synthroid) - an oral thyroid hormone medication used to treat hypothyroidism (under active thyroid gland);
LPN - Licensed Practical Nurse;
MAR - Medication Administration Record;
mcg-microgram;

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F 000	Continued From page 2 mL - Milliliter MDS - Minimum Data Set (standardized assessment forms used in nursing homes); NHA- Nursing Home Administrator; Novolog Insulin - a rapid-acting insulin used to lower blood sugar/ glucose; Ombudsman - resident representative who investigates reported complaints and helps to achieve agreement between parties; Osteoarthritis - a type of joint disease that results from breakdown of joint cartilage and underlying bone. The most common symptoms are joint pain and stiffness; POA - Power of Attorney; Pressure Ulcers (PUs) - sore area of skin that develops when the blood supply to it is cut off due to pressure; Propranolol - a medication that reduces the workload on the heart and help it to beat more regularly; Psychiatric-relating to mental illness or its treatment; RN - Registered Nurse; Stage II (2) Pressure Ulcer- skin blisters or skin forms an open sore. The area around the sore may be red and irritated; Stewardship - the job of supervising or taking care of something; T4 - also known as thyroxine, which is a hormone produced by the thyroid gland and helps control metabolism and growth; Vitamin D- a group of vitamins essential for the absorption of calcium.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence,	F 550		10/17/18

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F 550	Continued From page 3 self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by:	F 550		

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F 550	Continued From page 4 Based on observation and interview, it was determined that for one (R16) out of 22 sampled residents, the facility failed to promote care in a manner and environment that maintained or enhanced R16's dignity and respect in full recognition of his individuality. Findings include: During a dining observation in the third floor dining room on 8/27/18 at 12:10 PM, R16 was observed sitting in a Geri-chair and his lunch was placed on a tray table in front of him. R16 was facing towards a television and facing away from the other residents that were sitting at tables. E6 (CNA) was seated in a chair next to R16 feeding him lunch. An interview with E4 (LPN) on 8/27/18 at 12:18 PM revealed that staff placed R16 at a tray table facing away from other residents because there was no space at the tables for his Geri-chair. The facility failed to promote care in a manner and environment that maintained or enhanced R16's dignity and respect in full recognition of his individuality when they had him eat lunch by himself and on a tray table facing away from the other residents. Findings were reviewed with E2 (DON) and E3 (ADON) on 8/30/18 at approximately 1:00 PM.	F 550	F550 1. R16 is stable and had no adverse effects from this practice. R16 is placed at a table in dining with other residents for all meals. 2. Any resident using a Geri-chair can be at risk for this practice. A house audit performed will be conducted by DON/designee to identify any residents using Geri-chair. These identified residents will be observed to ensure proper seating arrangement for meals. 3. A root cause analysis was performed and the results will be presented at QAPI for further recommendations. Nursing staff will be in-serviced by DON/designee on appropriate placement of residents utilizing Geri-chairs during meals. 4. The DON/designee will audit meals to identify inappropriate placement of residents utilizing Geri-chairs for 3 meals a day for 1 week until 100% compliant; then 1 meal a day x 1 week until 100% compliant; then one meal a week x 2 weeks until 100% compliant. Results will be brought to QAPI for further recommendations.	
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to	F 578		10/17/18

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F 578	Continued From page 5 formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was	F 578	F578	

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F 578	Continued From page 6 determined that for one (R17) out of 22 sampled residents, the facility failed to honor R17's advanced directive. Findings include: Review of R17's clinical record revealed: R17's POA signed her advanced directive on 6/28/18, and stated that R17 was to have no weights. Review of R17's weight history revealed that on 7/2/18 and 8/1/18 staff weighed R17. The facility failed to follow R17's Advanced Directive which stated that R17 was to have no weights as of 6/28/18. Findings were reviewed with E2 (DON) and E3 (ADON) on 8/30/18 at approximately 1:00 PM.	F 578	1. R17 continues to reside in the facility and remains stable. R17 has not experience any adverse effects from this practice. All weights have been discontinued in accordance with the resident's /POA wishes. 2. Any residents' with advance directives/order has the potential to be affected by this practice. DON/designee will audit all resident orders to identify any advance directive/orders that state no weights. This list will be given to unit managers to ensure the facility follows resident' wishes. 3. A root cause analysis was performed and the results will be presented at QAPI. Any resident with an order of no weights will be kept at the nursing station as a reference for the nursing staff. The unit managers will bring list to morning clinical meeting for review of its accuracy. The nursing staff will be in-serviced on this new procedure by the DON/designee. 4. The DON/designee will audit the resident list for no weights during morning clinical meeting for accuracy daily x 1 week until 100|% compliant; then weekly x 2 weeks until 100% compliant. Results will be brought to QAPI for further recommendations.	
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer.	F 623		10/17/18

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F 623	Continued From page 7 Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days.	F 623		

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F 623	Continued From page 8 §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility	F 623		

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F 623	Continued From page 9 must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R33) out of 22 sampled residents, the facility failed to notify the resident and the resident's representative in writing of a facility discharge and the reason for the discharge, and they failed to send a copy to the ombudsman. Findings include: Review of R33's clinical record revealed: R33 was admitted to the facility on 9/20/17 and discharged to the hospital on 5/21/18 for psychiatric concerns. Review of R33's clinical record provided no evidence that R33 and R33's representative were notified in writing of the facility discharge. There was also no evidence that a copy of this notice was sent to the ombudsman. During an interview with E3 (ADON) on 8/29/18 at 2:42 PM, it was confirmed that the facility failed to notify R33 and R33's representative in writing of the facility discharge and the reason for the	F 623	F623 1. A letter will be sent to R33, R33's representative, and Ombudsman stating the reason of the Resident's discharge. 2. All residents who have been discharged are at risk for this practice. The DON/Designee will review the past 30 days of discharge and a letter will be sent to the identified resident, the resident's representative, and Ombudsman stating the reason for discharge. 3. A root cause analysis was performed and results will be presented at QAPI for further recommendations. A folder is placed at each nursing station with a form letter that will be filled out by a Licensed Nurse and given to residents upon discharge/transfer. A copy will be given to the Business Office Manager on the next working day to be mailed to the resident's	

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F 623	Continued From page 10 discharge and they failed to send a copy to the ombudsman. Findings were reviewed with E1 (ED) and E2 (DON) on 8/30/18 at 3:30 PM during the exit conference.	F 623	representative and Ombudsman. The licensed nursing staff and Business Office Manager will be in-serviced on this procedure by the Don/Designee. 4. The DON/Designee will audit all discharges daily to ensure letter of discharge was given to resident, representative, Ombudsman x 1 week until 100% compliant; then weekly x 2 weeks until 100% compliant. Results will be brought to QAPI for further recommendations.	
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At	F 625		10/17/18

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F 625	Continued From page 11 the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R33) out of 22 sampled residents, the facility failed to notify the resident and the resident's representative with a written notice that specified the duration of the bed-hold policy at the time of discharge to the hospital. Findings include: Review of R33's clinical record revealed: R33 was admitted to the facility on 9/20/17 and discharged to the hospital on 5/21/18 for psychiatric concerns. Review of R33's clinical record provided no evidence that R33 and R33's representative were provided, at the time of discharge to the hospital, a written notice which specified the duration of the bed-hold policy. During an interview with E3 (ADON) on 8/29/18 at 2:42 PM, it was confirmed that the facility failed to notify R33 and R33's representative in writing of the bed hold policy. E3 stated that the facility had no written notifications of their bed hold policy for the residents or the residents' family. Findings were reviewed with E1 (ED) and E2 (DON) at the exit conference on 8/30/18 at 3:30 PM.	F 625	F625 1. A letter will be sent to R33 and R33's representative with the bed hold policy. 2. All residents who have been discharged are at risk for this practice. The DON/Designee will review the past 30 days of discharge and a letter will be sent to the identified resident and the resident's representative with the bed hold policy. 3. A root cause analysis was performed and results will be presented at QAPI for further recommendations. A folder is placed at each nursing station with the bed hold policy that will be filled out by a Licensed Nurse and given to residents upon discharge/transfer. A copy will be given to the Business Office Manager on the next working day to be mailed to the resident's representative. The licensed nursing staff and Business Office Manager will be in-serviced on this procedure by the Don/Designee. 4. The DON/Designee will audit all discharges daily to ensure letter of discharge was given to resident and resident's representative x 1 week until 100% compliant; then weekly x 2 weeks	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 12	F 625	until 100% compliant. Results will be brought to QAPI for further recommendations.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of manufacturer's instructions, it was determined that for one (R17) out of 22 sampled residents, the facility failed to provide services to meet professional standards of quality. Findings include: Review of manufactures instructions revealed: The Novolog insulin aspart injection 100 Units/mL Highlights of Prescribing Information, last updated 3/16/17, stated, "Instructions For Use Novolog FlexPen ...Before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing ...Turn the dose selector to 2 units ...Hold your Novolog FlexPen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge ...Keep the needle pointing upwards, press the push-button all the way in ...The dose selector returns to 0 ...A drop of Insulin should appear at the needle tip. If not, change the needle and repeat the procedure no more than 6 times. If you do not see a drop of insulin after 6 times, do not use the Novolog FlexPen ..."	F 658	F658 1. Resident R17 remains stable and experienced no adverse effects from this practice. The facility cannot go back and correct this practice. 2. All residents receiving insulin through a pen is at risk for this practice. The DON/Designee will audit all residents' charts to identify the use of insulin pens and blood sugar results to identify any adverse effects from this practice. 3. A root cause analysis was performed and results will be presented at QAPI for further recommendation. Residents who using the insulin pen will have orders clarified adding the procedure for priming the insulin pen. DON/designee will in-service licensed nurses on procedures for priming insulin pens. 4. The DON/Designee will randomly observe five insulin administrations using	10/17/18

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F 658	Continued From page 13 During a medication administration on 8/29/18 at 11:39 AM, E5 (LPN) was observed giving R21 Novolog insulin 4 units using a FlexPen. E5 did not turn the Novolog FlexPen dose indicator to 2 units and tap the cartridge to get the air bubbles to the top, and did not press the push-button while pointing the needle upwards in order to prime the FlexPen prior to administration. On 8/29/18 at 11:42 AM, E5 stated that she was not aware that she needed to prime an insulin FlexPen and was not taught that it needed to be done every time prior to administration. The facility failed to provide services that met professional standards of practice by failing to administer insulin using R17's Novolog FlexPen per manufacturer's instructions and they failed to ensure that staff were educated on proper administration standards. Findings were reviewed with E2 (DON) and E3 (ADON) on 8/30/18 at approximately 1:00 PM.	F 658	an insulin pen on various shifts 5 times/week for 2 weeks until 100% compliant; then 5 insulin administrations using an insulin pen monthly x 1 month until 100% compliant. Results will be presented at QAPI for recommendation.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation and record review, it was determined that the facility failed to provide the necessary services to maintain good nutrition for one (R7) out of 22 residents. Findings include:	F 677	F677 1. R7 is stable and experienced no adverse effects from this practice. R7 will be fed as soon as food is placed in front	10/17/18

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F 677	Continued From page 14 Review of R7's clinical record revealed: R7 was admitted to the facility on 5/4/18 with declining functional status, osteoarthritis, and dementia. On 5/11/18, R7's Admission MDS Assessment Eating Functional Status indicated R7 required one person extensive assistance for eating. On 8/10/18, R7's Quarterly MDS Assessment Eating Functional Status indicated R7 required one person extensive assistance for eating. The following observations were made during lunch on 8/27/18: 12:22 PM - R7 was sitting in a chair asleep at the table; 12:27 PM - R7 put her head on the table with her eyes closed; 12:34 PM - E7 (CNA) was observed standing next to R7 and feeding her a spoonful of her lunch before returning to help another resident; 12:36 PM - R7 put her head back down on the table with her eyes closed; 12:50 PM - E7, who was sitting at another table, prompted R7 to eat her ice cream; 12:52 PM - E7 sat next to R7 and cued her to eat her lunch; and 12:58 PM - E7 began feeding R7 lunch. The facility failed to assist R7 for over 30 minutes before helping her to eat her lunch. Findings were reviewed with E2 (DON) and E3 (ADON) on 8/30/18 at 12:52 PM.	F 677	of resident. 2. All residents who need assistance with meals are at risk for this practice. The DON/Designee will review all residents' MDS to identify the need for assistance for meals and will observe the identified resident to ensure appropriate assistance is provided. 3. A root cause analysis was performed and results will be presented at QAPI for further recommendations. The DON/Designee will ensure that the information from the MDS matches the information on the Residents' PCC task section. The DON/Designee will in-service nursing staff on where to locate the residents' dining needs. 4. The DON/Designee will audit meals to ensure appropriate assistance is offered to residents 3 meals a day for 1 week until 100% compliant; then 1 meal per day x 1 week until 100% compliant; then one meal a week x 2 weeks until 100% compliant. Results will be presented to QAPI for further recommendations.	
F 684 SS=D	Quality of Care CFR(s): 483.25	F 684		10/17/18

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F 684	Continued From page 15 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that two (R7 and R29) out of 22 sampled residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. The facility failed to consistently document the percentage consumed of R7's nutritional supplement and they failed to follow the physician's order for R29 to hold her Propanolol for heart rates less than 60 on July 6 and Aug 13, 2018. Findings include: 1. Review of R29's clinical record revealed: R29 was admitted to the facility in 2014. 1/26/16- Review of a physician order for R29 stated to give Propanolol 60 mg tablet twice a day for essential tremor (nervous system disorder that causes rhythmic shaking)- hold for heart rate less than 60. 1/29/18- Review of R29's care plan for potential and/or actual alteration in cardiovascular status, developed on 1/12/18 and last revised on 1/29/18, stated, "Administer Meds (medications): ASA (Aspirin, medication), propanolol...".	F 684	F684 1. a. R29 remains in the facility and is stable. R29 experience no adverse effects from this practice. The facility cannot go back and correct this practice. b. R7 remains in the facility and is stable. R7 experienced no adverse effects from this practice. The facility cannot go back and correct this practice. 2. a. All residents taking Propanolol are at risk from this practice. The Don/Designee will review all residents who are receiving Propanolol within stated parameters to ensure that the medication was, if not within parameters, was held. b. All residents who receive Ensure are at risk from this practice. DON/Designee will audit identified residents to ensure consumption documentation. 3. a. A root cause analysis was performed and results will be presented at QAPI for further recommendations. Every resident	

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F 684	Continued From page 16 MAR reviews revealed the following: July 2018- on 7/6/18 at 8:00 AM, R29 was given Propanolol although her heart rate was 58 and should have been held. August 1-27, 2018- on 8/13/18 at 8:00 AM, R29 was given Propanolol although her heart rate was 58 and should have been held. 8/30/18- Findings were reviewed and confirmed with E3 (ADON) at 11:00 AM. 2. Review of R7's clinical record revealed: On 5/4/18 there was a doctor's order for R7 to receive a nutritional supplement three times a day. On 5/17/18 there was a doctor's order for R7 to receive a nutritional supplement four times a day. A care plan goal, initiated on 8/2/18, stated R7 was to consume 100% of the supplement as ordered through the next review. Review of R7's Medication Administration Record (MAR) for May 2018 revealed documentation of the percentage of supplement consumed from May 5, 2018 through May 17, 2018 only. Review of R7's MAR for June 2018 revealed no documentation of the percentage of supplement consumed throughout June 2018. Review of R7's MAR for July 2018 revealed no documentation of the percentage of supplement consumed throughout July 2018.	F 684	receiving Propanolol and have parameters ordered will have a corresponding order that will highlight the parameters for the licensed nurses. The DON/Designee will in-service licensed nursing staff on the parameter orders. b. A root cause analysis was performed and results will be presented at QAPI for further recommendations. Every resident receiving Ensure will have a corresponding order that the nursing staff will have to enter the amount consumed. The DON/Designee will in-service the licensed nursing staff on the consumption documentation. 4. a. The DON/Designee will review all Propanolol parameter documentation daily x 1 week until 100% compliant; then 3 times a week for 2 weeks until 100% compliant; then 2 times a month for 1 month until 100% compliant. Results will be presented to QAPI for further recommendations. b. The DON/Designee will review 10% of the residents receiving Ensure documentation of consumption once a day for 1 week, the 3 times a week for 2 weeks, then weekly for 2 weeks until 100% compliant. Results will be presented to QAPI for further recommendations.	

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F 684	Continued From page 17 Review of R7's MAR for August 2018 revealed documentation of the percentage of supplement consumed from August 16, 2018 through August 29, 2018 only. The facility failed over a four month period, to consistently monitor and document the percentage consumed of R7's nutritional supplement. Findings were reviewed with E2 (DON) and E3 (ADON) on 8/30/18 at 12:52 PM.	F 684		
F 686 SS=E	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, it was determined that for one (R17) out of 22 sampled residents, the facility failed to ensure that a resident with a pressure ulcer received the necessary treatment and services, consistent with professional standards of	F 686	F686 1. R17 remains in the facility and has no adverse effects from this practice. The facility cannot go back and correct this practice.	10/17/18

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F 686	Continued From page 18 practice. For R17, a dependent resident with a stage II right ischium pressure ulcer, the facility lacked evidence that R17 was consistently turned side to side to prevent skin breakdown. Findings include: Review of R17's clinical record revealed: R17 was admitted to the facility on 9/23/16 with diagnoses that included Alzheimer's disease and essential tremors. Review of R17's care plan revealed that starting on 2/13/18, revised on 3/22/18, R17 had the potential for impairment to skin integrity and pressure ulcers due to limited mobility, incontinence and skin fragility from aging. Interventions did not include turning and repositioning R17. R17's 6/20/18 Quarterly MDS assessment stated that R17 required extensive assistance of 2 staff members for bed mobility and transfers. In addition, the MDS stated that R17 was at risk for pressure ulcers and was not on a turning and repositioning program. Review of R17's CNA kardex stated that R17 was to be turned and repositioned every 2 hours. R17's documentation survey report from June 2018- August 2018 revealed that there were no shifts where staff initialed every 2 hours indicating that R17 was turned and repositioned. Staff only documented turning the resident every 2 hours one time for the whole shift. In addition, staff often documented turning and repositioning R17 every 2 hours for the whole shift 1 to 8 hours prior to the end of their shift. Staff also, at times, did not document turning R17 at all for the whole shift or	F 686	2. All residents with pressure ulcers are at risk for this practice. The DON/Designee will review all residents with pressure ulcers to ensure appropriate documentation of turning and positioning. 3. A root cause analysis was performed and results will be presented at QAPI for further recommendations. PCC documentation for turning and repositioning was reviewed and noted that the staff should be documenting at the end of the shift that the resident was turned and repositioned. The licensed nursing staff will also document in PCC that the resident was turned and repositioned every 2 hours. The DON/Designee will in-service nursing staff on the documentation expectation regarding turning and repositioning. 4. The DON/Designee will audit turning and repositioning documentation on all residents with pressure ulcers daily for 1 week until 100% compliant; then weekly for 2 weeks until 100% compliant. Results will be presented to QAPI for further recommendations.	

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F 686	Continued From page 19 answered no that R17 had not been turned and repositioned that shift. On 8/7/18 at 1:19 PM, a wound assessment documented that R17 had a new stage II pressure ulcer to her right ischium that was acquired while in the facility. During an interview on 8/30/18 at 8:27 AM, E4 (LPN) stated that staff turn R17 every 2 hours. E4 stated that nursing staff verified every 2 hours that R17 was turned and repositioned and it was documented on the Turning Schedule Accountability Sheet. E4 stated that at the end of the day the Turning Schedule Accountability Sheet was discarded and the only permanent documentation showing that R17 was being turned and repositioned every 2 hours was the CNA's documentation on the documentation survey report. The facility failed to ensure that R17, a dependent resident with a stage II right ischium pressure ulcer, was consistently turned and repositioned every 2 hours to prevent skin breakdown.	F 686		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the	F 756		10/17/18

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F 756	Continued From page 20 facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and review of the manufacturer's instructions it was determined that for one (R27) out of 22 sampled residents, the facility's pharmacist failed to identify medication irregularities during the monthly medication regimen reviews (MRRs). Findings include: The Synthroid websites Full Prescribing Information, dated 2018, stated, "Drugs That May	F 756	F756 1. R27 remains in the facility and is stable. The Levothyroxine and Calcium Carbonate administration times have been scheduled 4 hours apart. 2. All residents receiving Levothyroxine and Calcium Carbonate are at risk for this practice. The DON/Designee will	

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F 756	Continued From page 21 Decrease T4 Absorption (hypothyroidism). Potential impact: Concurrent use may reduce the efficacy of Synthroid by binding and delaying or preventing absorption, potentially resulting in hypothyroidism ...Calcium Carbonate may form an insoluble chelate with levothyroxine ...Administer Synthroid at least 4 hours apart from these agents" Review of R27's clinical record revealed: R27 was admitted to the facility on 10/22/15 with diagnoses that included hypothyroidism. On 10/22/15, R27 had a physician's order for Calcium Carbonate with Vitamin D 250 mg- 125 mg tablet give 1 tablet by mouth two times a day as a supplement. This order was entered to be administered at 9:00 AM and 4:00 PM. On 5/16/17, R27 had a physician's order for Levothyroxine Sodium 75 mcg tablet give 1 tablet by mouth one time a day every Sunday, Monday, Wednesday, Friday, and Saturday for hypothyroidism. This order was entered to be administered at 6:00 AM. On 5/16/17, R27 had a physician's order for Levothyroxine Sodium 88 mcg tablet give 1 tablet by mouth one time a day every Tuesday and Thursday for hypothyroidism. This order was entered to be administered at 6:00 AM. An MRR was completed by the consultant pharmacist for R27 from October 2017 through July 2018 with irregularities identified on 11/2/17, 1/3/18, 4/16/18, 5/2/18, 6/11/18, and 7/17/18. These did not include any recommendations regarding the timing of administration for R27's	F 756	complete an audit of those identified residents receiving these medications to ensure there are 4 hours separating administration. 3. A root cause analysis was performed and results will be presented at QAPI for further recommendations. The Pharmacist will be inserviced by the Regional Pharmacist on the recommended timing of Levothyroxine and Calcium Carbonate. 4. The DON/Designee will audit Levothyroxine and Calcium Carbonate administration monthly for 1 month until 100% compliance. Results will be presented to QAPI for further recommendations.	

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F 756	Continued From page 22 Levothyroxine Sodium and Calcium Carbonate with Vitamin D. The pharmacist failed to recognize during R16's MRR's from October 2017 through July 2018 the error of the facility administering R16's Levothyroxine Sodium and Calcium Carbonate with Vitamin D less than 4 hours apart. R16 received Levothyroxine Sodium at 6 AM and Calcium Carbonate at 9 AM which was 3 hours apart. Findings were reviewed with E2 (DON) and E3 (ADON) on 8/30/18 at approximately 1:00 PM.	F 756		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following	F 880		10/17/18

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F 880	Continued From page 23 accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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	08A011	A. BUILDING _____ B. WING _____	08/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE STAR FOULK MANOR NORTH LLC	1212 FOULK ROAD WILMINGTON, DE 19803

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F 880	Continued From page 24 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility documentation and interview it was determined that the facility failed to implement surveillance of the practices of staff directly related to resident care in order to identify whether staff implemented and complied with the facility's infection control program policies and procedures. Findings include: Review of the facility infection control documentation lacked evidence that the facility was analyzing, reviewing, and documenting any follow up activity in response to collected surveillance data. On 8/30/18 at 11:51 AM, during an interview, E2 (DON) confirmed that the facility failed to ensure ongoing surveillance of proper infection control procedures carried out by the staff. Findings were reviewed on 8/30/18 with E1 (ED) and E2 (DON) at the exit conference.	F 880	F880 1. No resident was adversely affected by this practice. The facility cannot correct this past action. 2. All residents have the potential to be affected by this practice. The facility cannot correct this past practice. 3. A root cause analysis was performed and results will be presented at QAPI for further recommendations. The DON will be in-serviced by the Regional Director of Health Services on implementing a surveillance of infection control practices of staff directly related to resident care. 4. The ED/DON will audit the surveillance program monthly for 2 months until 100% compliant. Results will be presented to QAPI for further recommendations.	
F 881 SS=F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 881		10/17/18

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F 881	Continued From page 25 §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on review of facility documentation and interview, it was determined that the facility failed to establish an antibiotic stewardship program that included education for staff and residents about antibiotic stewardship. Findings include: Review of the facility's infection control documentation lacked evidence that the facility was conducting an antibiotic stewardship program that included antibiotic use protocols and a system to monitor antibiotic use. On 8/30/18 at 11:51 AM, during an interview, E2 (DON) confirmed that the facility did not educate all staff and residents about antibiotic stewardship. The facility failed to implement an antibiotic stewardship program. Findings were reviewed on 8/30/18 with E1 (ED) and E2 (DON) at the exit interview.	F 881	F881 1. No resident was adversely affected by this practice. The facility cannot correct this past action. 2. All residents have the potential to be affected by this practice. The facility cannot correct this past practice. 3. A root cause analysis was performed and results will be presented at QAPI for further recommendations. The DON will be in-serviced by the Regional Director of Health Services on the antibiotic stewardship program. The DON/Designee will in-service the licensed nursing staff on the antibiotic stewardship program. 4. The ED/DON will audit the educational program for compliance once a month for 2 months until 100% compliant. Results will be presented to QAPI for further recommendations.	
F 908 SS=C	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by:	F 908		10/17/18

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F 908	Continued From page 26 Based on observation, the facility failed to safely maintain an internal fan in a walk-in refrigerator in the kitchen. Findings include: On 8/27/18 at 9:08 AM, during the initial kitchen tour, the internal fan in the walk-in refrigerator was observed to be dusty. E9 (FSD) was notified immediately. The facility failed to assure that all mechanical equipment was maintained in a safe operating condition. Findings were discussed with E1 (ED) and E2 (DON) on 8/30/18 during the exit conference.	F 908	F908 1. No residents were affected by this practice. The facility contacted the repair service and the fan was fixed. 2. All residents have the potential to be affected by this action. The repair service responded and the fan was fixed. 3. A root cause analysis was performed and results will be presented at QAPI for further recommendations. The Maintenance Director will add the inspection of the refrigerator fan on the monthly environmental rounds. The Environmental Department will be in-serviced by ED/Designee on this procedure. 4. The ED/Designee will inspect the refrigerator fan operation monthly for 2 months until 100% compliant. Results will be presented to QAPI for further recommendations.	
F 920 SS=D	Requirements for Dining and Activity Rooms CFR(s): 483.90(h)(1)-(4) §483.90(h) Dining and Resident Activities The facility must provide one or more rooms designated for resident dining and activities. These rooms must-- §483.90(h)(1) Be well lighted; §483.90(h)(2) Be well ventilated; §483.90(h)(3) Be adequately furnished; and	F 920		10/17/18

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F 920	Continued From page 27 §483.90(h)(4) Have sufficient space to accommodate all activities. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to have sufficient space to conduct dining in one (third floor dining room) of the resident dining rooms. Findings include: During a dining observation in the third floor dining room on 8/27/18 at 12:10 PM, R16 was observed sitting in a Geri-chair and his lunch was placed on a tray table in front of him. E6 (CNA) was seated in a chair next to R16 who was feeding him lunch. An interview with E4 (LPN) on 8/27/18 at 12:18 PM revealed that staff placed R16 at a tray table and not at a table with other residents, because there was not enough space at the tables in the dining room to accommodate his Geri-chair. The facility failed to provide sufficient space to accommodate dining activities in the 3rd floor dining room during a lunch dining observation on 8/27/18. Findings were reviewed with E2 (DON) and E3 (ADON) on 8/30/18 at approximately 1:00 PM.	F 920	F920 1. R16 continues to reside in the facility and has had no adverse effects by this action. The dining room furniture was rearranged and can accommodate the Geri-chair. 2. All residents who use Geri-chairs are at risk for this action. The dining room furniture was rearranged so that the room can accommodate Geri-chairs. 3. A root cause analysis was performed and results will be presented at QAPI for further recommendations. The DON/Designee will in-service nursing staff on appropriate seating arrangement to accommodate Geri-chairs. 4. The DON/Designee will observe dining services to ensure that there is appropriate room for Geri-chairs weekly for 1 month, then monthly for 2 months until 100% compliance. Results will be presented to QAPI for further recommendations.	
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for	F 921		10/17/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 921	Continued From page 28 residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to provide a fully functional bathroom sink for one (R21) out of 22 sampled residents. Findings include: On 8/27/18 at 9:55 AM, during a tour of Room 214, it was observed that there was poor water flow from the bathroom sink. On 8/30/18 at 10:53 AM during a tour with E8 (maintenance supervisor), it was confirmed that there was poor water flow from the bathroom sink in Room 214. The facility failed to provide reasonable accommodation of properly flowing water in the bathroom sink. Findings were reviewed with E1 (ED) and E2 (DON) on 8/30/18 at approximately 3:30 PM.	F 921	F921 1. R21 remains in the facility and has had no adverse effects from this action. R21's faucet was found to not be operating correctly. R21's faucet was replaced immediately and suffered no adverse effects from this action. The faucet remains functional at optimum water flow. 2. All residents with poor water flow can be affected by this action. All bathroom sinks will be inspected for appropriate flow of water an any identified with poor water flow will have faucets replaced. 3. A root cause analysis was performed and results will be presented at QAPI for further recommendations. Inspection of water flow of bathroom sinks will be added to the monthly environmental rounds. The ED/Designee will in-service the Environmental department on the addition of the inspection of the water flow of bathroom sinks. 4. The ED/Designee will conduct a random audit of 10% bathroom sinks□ water flow weekly for 2 weeks until 100% compliance, then monthly for 2 months until 100% compliance. Results will be presented to QAPI for further recommendations.	

DELAWARE HEALTH
AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long Term Care
Residents Protection

3 Mill Road, Suite 306
Wilmington, Delaware 19806
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Five Star Foulk Manor North DATE SURVEY COMPLETED: August 30, 2018

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual and emergency preparedness survey was conducted at this facility from August 27, 2018 to August 30, 2018. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 34. The survey sample was 22. During this period, an Emergency Preparedness survey was also conducted by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection in accordance with 42 CFR 483.73. **Regulations for Skilled and Intermediate Care Facilities** **Scope**	State Def 6.9.2.4 1. E10 will be given a 2nd step TST. 2. All residents have the potential to be affected by this practice. All new employees' records from the past 6 months will be reviewed and any missed TST will be given.	10/17/2018
3201 3201.1.0 3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by the following:** Cross Refer to the CMS 2567-L survey completed August 30, 2018: F550, F578, F623, F625, F658, F677, F684, F686, F756, F880, F881, F908, F920, and F921. **Communicable Diseases** **Specific Requirements for Tuberculosis** **Minimum requirements for pre-employment tuberculosis testing require all employees to have a base line two-step tuberculin skin test.**	3. A root cause analysis was performed and results will be presented at QAPI for further recommendations. A log has been developed that tracts the potential employee's TST to ensure that 2 steps are given prior to employment. The ED/Designee will in-service the HR Department on the tracking sheet and pre-employment TSTs.	
320. 320	Based on record review and interview it was determined that the facility failed to ensure TB (tuberculin) testing was done in accordance with The Centers for Disease Control and Prevention (CDC) TB test-	4. The ED/Designee	

Provider's Signature Sue Haines Title Administrator Date 9/24/18

NAME OF FACILITY: Five Star Foulk Manor North DATE SURVEY COMPLETED: August 30, 2018

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
6.9 6.9.2 6.9.2.4	ing guidelines for one (E10) out of 10 reviewed employees. Findings include: Since immune response declines with age, CDC guidelines for Tuberculin Skin Testing (5/11/16) documented the ability to react to the skin test diminishes years after infection creating a false-negative reaction [person has TB infection but skin test does not show it]. The skin test may stimulate the immune system causing a positive reaction on subsequent tests. Giving a second test after the initial one is called two-step testing. Two-step testing is useful for the initial testing of adults who would be tested periodically, to reduce the chance of a boosted reaction. https://www.cdc.gov/tb/publications/factsheets/testing/skintesting.htm Review of E10's employee record revealed: 4/16/18 – Tuberculin skin test (TST) performed. Result negative. 5/14/18 – First day of employment in the facility. There was no evidence in the record of a second TST performed on E10. 8/30/18 9:53 AM– Interview with E3 (ADON) confirmed E10 never received a second TST. The finding was reviewed with E1 (ED) and E2 (DON) during the exit conference on 8/30/18.	will audit tracking logs weekly for 2 weeks until 100% compliance, then monthly for 2 months until 100% compliance. Results will be presented to QAPI for further recommendations.	

Provider's Signature Sue Haines Title Administrator Date 9/24/18